

Overview of Health Care Changes in the FY2015 House Budget

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Summary

On April 1, 2014, House Budget Committee Chairman Paul Ryan released the chairman's mark of the FY2015 House budget resolution together with his non-binding report entitled *The Path to Prosperity: Fiscal Year 2015 Budget Resolution*, which outlines his budgetary objectives. The House Budget Committee considered and amended the chairman's mark on April 2, 2014, and voted to report the budget resolution to the full House. H.Con.Res. 96 was introduced in the House April 4, 2014, and was accompanied by the committee report (H.Rept. 113-403). H.Con.Res. 96 was agreed to by the House on April 10, 2014.

Once it is agreed to by both chambers of Congress, a budget resolution provides enforceable budgetary parameters; however, it is not a law. Changes to programs that are assumed or suggested by the budget resolution would still need to be enacted in separate legislation. Chairman Ryan's budget proposal, as outlined in his report and in the committee report, suggests short-term and long-term changes to federal health care programs, including to Medicare, Medicaid, and the health insurance exchanges established by the Patient Protection and Affordable Care Act as amended (ACA, P.L. 111-148, P.L. 111-152).

Within the 10-year budget window (FY2015-FY2024), the budget allows for the full repeal of the ACA or just certain provisions, including those that reduce Medicare spending, those that expand Medicaid coverage to the non-elderly with incomes up to 133% of the federal poverty level, and those provisions that establish health insurance exchanges. Committee documents also suggest restructuring Medicaid from an individual entitlement program to a block grant program. In addition, beginning in 2024, the budget assumes the conversion of Medicare to a fixed federal contribution ("premium support") program.

This report summarizes the proposed changes to Medicare, Medicaid, and private health insurance as described in H.Con.Res. 96 and accompanying documents, including the committee report and Chairman Ryan's *Path to Prosperity* report.

Contents

Introduction	1
Health Care Related Reserve Funds in H.Con.Res. 96	2
Medicare	3
Short-Term Medicare Changes (FY2015-FY2024)	4
Long-Term Medicare Changes (FY2024 and Beyond)	7
Age of Medicare Eligibility	7
Conversion of Medicare to a Premium Support System	7
Medicaid	9
Repeal of Certain Medicaid Provisions in ACA	9
Conversion of Medicaid to a Block Grant System	10
Reductions to Federal Medicaid Funding	10
Private Health Insurance	11
Repeal of Private Health Insurance Provisions in ACA	11
Other Health Care Proposals	12
Medical Malpractice	12

Contacts

Author Information	13
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Introduction

On April 1, 2014, Representative Paul Ryan, the chairman of the House Budget Committee, released the chairman's mark of the FY2015 House budget resolution.¹ Additional detail on budgetary objectives and justifications was provided in Chairman Ryan's report entitled *The Path to Prosperity: Fiscal Year 2015 Budget Resolution*, issued the same day.² The House Budget Committee considered the chairman's mark on April 2, 2014, and voted 22-16 to report the budget resolution to the full House. H.Con.Res. 96 was introduced in the House April 4, 2014, and was accompanied by the House Budget Committee Report (H.Rept. 113-403).³ The Congressional Budget Office (CBO) did not provide an analysis of the health care provisions in the proposed FY2015 budget.⁴ The House agreed to H.Con.Res. 96 on April 10, 2014, by a vote of 219-205.⁵

A budget resolution, if agreed to by both the House and Senate, sets enforceable budgetary parameters.⁶ Among other things, H.Con.Res. 96 expresses the desired levels of spending for government health programs over 10 years (FY2015-FY2024), creates four health care-related reserve funds, and presents policy statements regarding assumptions about future Medicare reforms and replacing the Patient Protection and Affordable Care Act as amended (ACA, P.L. 111-148, P.L. 111-152). H.Con.Res. 96 does not include instructions for reconciliation.⁷ A budget resolution is not intended to establish details of spending or revenue policy and does not provide levels of spending for specific agencies or programs. It is not a law and is not signed by the President. Rather, a budget resolution provides the framework for the consideration of subsequent legislation. While the House budget resolution suggests and assumes certain health care-related policy changes, separate legislation would need to be developed by the committees of jurisdiction, passed by Congress, and signed by the President in order for such changes to be made to the affected federally funded health care programs.

In general, the budget proposal, as outlined in Chairman Ryan's *Path to Prosperity* report and in the committee report, suggests a change in the structure of the Medicare and Medicaid programs; the repeal of many (or all) of the provisions in the ACA, including those that establish insurance exchanges; and changes to tort law governing medical malpractice.

¹ The press release may be found at <http://budget.house.gov/news/documentsingle.aspx?DocumentID=374739>.

² This report may be found at http://budget.house.gov/uploadedfiles/fy15_blueprint.pdf.

³ These documents may be found at <http://www.gpo.gov/fdsys/pkg/BILLS-113hconres96rh/pdf/BILLS-113hconres96rh.pdf> and <http://www.gpo.gov/fdsys/pkg/CRPT-113hrpt403/pdf/CRPT-113hrpt403.pdf>.

⁴ CBO provided a long-term analysis of the FY2012 and FY2013 House Budget Medicare proposals, but did not provide a similar analysis for the FY2014 or FY2015 proposals. See CBO's April 1, 2014, blog entitled "CBO's Role in Budget Resolutions" at <http://www.cbo.gov/publication/45216>. CBO did issue a broader analysis of the proposal's potential long-term economic impact entitled *Budgetary and Economic Outcomes under Paths for Federal Revenues and Noninterest Spending Specified by Chairman Ryan*, April 2014, at <http://www.cbo.gov/publication/45211>.

⁵ The House passed version of H.Con.Res. 96 may be found at <http://www.gpo.gov/fdsys/pkg/BILLS-113hconres96eh/pdf/BILLS-113hconres96eh.pdf>.

⁶ For more information on the budget process and budget resolutions, see CRS Report 98-721, *Introduction to the Federal Budget Process*, coordinated by Bill Heniff Jr., and CRS Report R40472, *The Budget Resolution and Spending Legislation*, by Megan S. Lynch.

⁷ Such instructions were provided in the FY2014 budget resolution, H.Con.Res. 25. For details on the reconciliation process, see CRS Report R41151, *Budget Reconciliation Process: Timing of Committee Responses to Reconciliation Directives*, by Megan S. Lynch.

This CRS report provides a synopsis of the health care-related changes in the House FY2015 budget proposal. This summary is based on the text of the Concurrent Resolution, the committee report, the FY2015 *Path to Prosperity* report, and the Budget Committee's frequently asked question document entitled *Setting the Record Straight*.⁸ CRS provided similar summaries of the health care changes suggested in the FY2012, FY2013, and FY2014 House budget proposals.⁹

Health Care Related Reserve Funds in H.Con.Res. 96

Reserve funds provide the chair of the Budget Committee the authority to adjust the budgetary levels in the budget resolution in the future, if certain conditions are met. Typically such conditions consist of legislation dealing with a particular policy being considered on the floor. Once this action has taken place, the Budget Committee chairman submits the revised levels to his respective chamber. Generally, the goal of such a reserve fund is to allow certain policies to be considered on the floor without triggering a point of order for violating levels in the budget resolution. Often, but not always, reserve funds require that the underlying legislative language be deficit-neutral. Typically, such deficit-neutral reserve funds allow for a committee to report specific policy legislation that violates the committee's spending allocation, as long as the excess amount is "offset" by equivalent amounts.

H.Con.Res. 96 contains four reserve funds related to federal health care programs. Section 301 of H.Con.Res. 96 would create a reserve fund to allow for the consideration of legislation that would fully repeal the ACA as amended, even if the legislation were projected to increase the deficit. Section 302 would allow for the consideration of legislation that would reform or replace the ACA, as long as the legislation would not increase the deficit over the period of FY2015 through FY2024. Similarly, Section 303 would create a reserve fund to allow for the consideration of legislation that would repeal all or some of the Medicare-related ACA provisions that reduce program spending, as long as the legislation were deficit-neutral for the FY2015-FY2024 period. The fourth reserve fund, created in Section 304, would allow for a deficit-neutral fix to the Medicare physician payment system (see "Short-Term Medicare Changes (FY2015-FY2024)").

While the reserve funds allow for flexibility in considering subsequent legislation affecting federal health care programs, the two health care policy statements in H.Con.Res. 96,¹⁰ as well as the committee report and the *Path to Prosperity* and *Setting the Record Straight* documents, provide more specific assumptions and suggestions of changes to these programs. The following sections of this report describe those specific proposals.

⁸ House of Representatives, Committee on the Budget, *Setting the Record Straight*, at <http://budget.house.gov/fy2015/settingtherecordstraight.htm>.

⁹ See CRS Report R43017, *Overview of Health Care Changes in the FY2014 Budget Proposal Offered by House Budget Committee Chairman Ryan*; CRS Report R42441, *Overview of Health Care Changes in the FY2013 Budget Proposal Offered by House Budget Committee Chairman Ryan*; and CRS Report R41767, *Overview of Health Care Changes in the FY2012 Budget Offered by House Budget Committee Chairman Ryan*, all by Patricia A. Davis, Alison Mitchell, and Bernadette Fernandez. As CBO had provided analyses for the FY2013 and FY2012 budget proposals based on additional information given to them by Budget Committee staff, and did not provide a similar analysis for FY2014 or FY2015, the earlier reports provide more details on certain assumptions.

¹⁰ Section 603, *Policy Statement on Replacing the President's Health Care Law*, and Section 604, *Policy Statement on Medicare*.

Medicare

Medicare is the nation's federal insurance program that pays for covered health services for most persons 65 years old and older and for most permanently disabled individuals under the age of 65. In FY2014, the program will cover an estimated 54 million persons at an estimated total cost of \$618 billion. CBO estimates that federal Medicare spending (after deduction of beneficiary premiums and other offsetting receipts) will be about \$518 billion in FY2014, accounting for over 14% of total federal spending and close to 3% of GDP.¹¹ Medicare is an entitlement program, which means that it is required to pay for covered services provided to eligible persons so long as specific criteria are met. Spending under the program (except for a portion of the administrative costs) is considered mandatory spending and is not subject to the appropriations process.

The Medicare program has four parts, each responsible for paying for different benefits, subject to different eligibility criteria and financing mechanisms.¹² Medicare Part A covers inpatient hospital services, skilled nursing care, some home health, and hospice care. Part A services are paid for out of the Hospital Insurance Trust Fund (HI), which is mainly funded by a dedicated payroll tax of 2.9% of earnings of current workers, shared equally between employers and workers. Part B covers physician services, outpatient services, medical equipment, ambulance services, laboratory tests, and some home health services; Part D covers outpatient prescription drugs. Parts B and D benefits are paid for out of the Supplementary Insurance Trust Fund (SMI), which is primarily funded through beneficiary premiums and federal general revenues. High-income beneficiaries pay higher premiums for Parts B and D, and certain low-income beneficiaries may receive assistance from Medicare and/or Medicaid with premiums and cost-sharing. Part C, called Medicare Advantage, is a private health plan option for beneficiaries that covers all Part A and B services, except hospice, and is funded through both the HI and SMI trust funds.¹³

Under traditional Medicare, Parts A and B, services are generally paid directly by the government on a "fee-for-service" basis, using different prospective payment systems or fee schedules.¹⁴ Under Parts C and D, private insurers are paid a set monthly per person amount to provide coverage to enrollees, and plan payments are adjusted to reflect the higher relative costs of sicker beneficiaries. Premium amounts may vary, depending on which plan the enrollee selects.

Since its enactment in 1965, the Medicare program has undergone considerable change. Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of deficit reduction legislation passed by Congress.¹⁵

¹¹ Congressional Budget Office, *April 2014 Medicare Baseline*, April 14, 2014, at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf>.

¹² For additional detail on the Medicare program and its financing, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga, and CRS Report R43122, *Medicare Financial Status: In Brief*, by Patricia A. Davis.

¹³ About 28% of Medicare beneficiaries are enrolled in MA.

¹⁴ Under a *prospective payment system* (PPS), Medicare payments are made using a predetermined, fixed amount based on the classification system for a particular service. CMS uses separate PPSs to reimburse acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. A *fee schedule* is a listing of fees used by Medicare to pay doctors or other providers/suppliers. Fee schedules are used to pay for physician services, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies in certain locations.

¹⁵ For brief history of changes to the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

With a few exceptions, reductions in program spending have been achieved largely through freezes or reductions in payments to providers, primarily hospitals and physicians, and by making changes to beneficiary premiums and other cost-sharing requirements. Most recently, the ACA made numerous changes to the Medicare program that modify provider and Medicare Advantage plan reimbursement methodologies, create incentives to improve the quality and efficiency of care, and provide additional program integrity tools and funding. Except in a few instances where the ACA enhanced coverage, it did not make any changes to Medicare benefits.¹⁶

Short-Term Medicare Changes (FY2015-FY2024)

H.Con.Res. 96 suggests total Medicare outlays of \$6.8 trillion over the 10-year budget window (FY2015-FY2024).¹⁷ According to estimates provided in the *Path to Prosperity* document, this level of outlays is about \$129 billion less than projected spending based on current policy.¹⁸ Baseline projections are based on current law, and therefore assume the continuation of ACA Medicare plan and provider payment reductions, physician payment reductions under the sustainable growth rate system (SGR) beginning in 2015,¹⁹ and 2% reductions in Medicare benefit spending under Budget Control Act of 2011 sequestration requirements.²⁰ Therefore, for the proposed spending levels to be attained, the expected reductions under current law, or equivalent reductions, would need to occur. Other policies would also need to be adopted to achieve the additional proposed savings. However, as described later in this section, the budget resolution provides for some flexibility in these spending levels.

The committee report suggests several policy options to reduce Medicare spending over the next 10 years. These include (1) additional means-testing of Parts B and D premiums for high-income

¹⁶ For details on individual Medicare provisions in the ACA, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.

¹⁷ H.Con.Res. 96, Section 102, Medicare (Budget Function 570).

¹⁸ *Path to Prosperity*, Table S-4, p. 92.

¹⁹ Medicare payments for Part B services provided by physicians and certain non-physician practitioners are made on the basis of a fee schedule, a list of over 7,000 tasks and services for which physicians bill Medicare. The sustainable growth rate (SGR) system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services. Each year since 2002, the SGR has resulted in a reduction in the reimbursement rates. With the exception of 2002, when a 4.8% decrease was applied, Congress has passed a series of bills to override the reductions. Most recently, the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) provides an override of the SGR-mandated reductions through March 31, 2014. CBO estimates that it would cost \$124 billion over the next 10 years (FY2015-FY2024) to eliminate these reductions. (CBO, *Updated Budget Projections: 2014 to 2024*, supplemental data on "Budgetary Effects of Selected Policy Alternatives Not Included in CBO's Baseline," April 14, 2014, at <http://www.cbo.gov/publication/45229>.) For further information, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn.

²⁰ The Budget Control Act of 2011 (BCA; P.L. 112-25) provided for increases in the debt limit and established procedures designed to reduce the federal budget deficit, including the creation of a Joint Select Committee on Deficit Reduction. The failure of the Joint Committee to propose deficit reduction legislation by its mandated deadline triggered automatic spending reductions ("sequestration" of mandatory spending and reductions in discretionary spending) in fiscal years 2013 through 2021. The American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240) delayed the automatic reductions by two months, while the Bipartisan Budget Act of 2013 (BBA, P.L. 113-67) extended sequestration for mandatory spending for an additional two years—through FY2023. On February 15, 2014, the President signed into law an amended version of S. 25 (P.L. 113-82), which, among other things, included a provision to extend BCA's sequester of mandatory spending through FY2024. Also see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan, and CRS Report R43411, *The Budget Control Act of 2011: Legislative Changes to the Law and Their Budgetary Effects*, by Mindy R. Levit.

seniors similar to that proposed in the President's FY2014 budget;²¹ (2) medical liability insurance reforms (see the "Medical Malpractice" section of this report);²² and (3) increased program integrity efforts to reduce improper payments.²³ The *Setting the Record Straight* document also suggests that savings could be realized through the repeal of the ACA provisions that close the Part D prescription drug benefit "doughnut hole."²⁴

The proposed restructuring of Medicare, described in the "Long-Term Medicare Changes (FY2024 and Beyond)" section below, would begin in the last year of the 10-year budget window, FY2024. Whether this change would lead to program costs or savings in that year would depend on how the system is structured, how many people were enrolled, and on the extent of the administrative related expenditures needed to set up the new program.

Flexibility in Proposed Spending Levels

The reserve funds described in "Health Care Related Reserve Funds in H.Con.Res. 96" allow the Chairman of the Committee on the Budget to revise allocations of spending for Medicare and to adjust other budgetary levels. For instance, the fund created by Section 302 of H.Con.Res. 96 allows for the consideration of legislation to reform or replace the ACA as long as it is deficit-neutral,²⁵ and the reserve fund in Section 303 allows for the consideration of deficit-neutral legislation to repeal some or all of the ACA provisions expected to decrease Medicare spending.²⁶ Both of these reserve funds would allow for the consideration of legislation that would increase Medicare spending, as long as those increases were offset by decreased spending somewhere else in the federal budget (the provisions do not specify that the increased spending must be offset within the Medicare budget category). On the other hand, the reserve fund created by Section 301 would allow for legislation to fully repeal the ACA, including all of the Medicare provisions,

²¹ H.Rept. 113-403, p. 81. See CRS Report R43073, *Centers for Medicare & Medicaid Services: President's FY2014 Budget*, coordinated by Alison Mitchell.

²² H.Rept. 113-403, p. 81.

²³ H.Rept. 113-403, p. 96. Title VI of the ACA contains numerous program integrity related provisions. As the budget proposal suggests the full repeal of the ACA as an option, it is not clear whether the proposed program integrity changes would be similar to or different from those in the ACA. For a summary of the existing provisions, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.

²⁴ *Setting the Record Straight*, response to question "Does this budget reinstate the so-called Medicare 'donut hole'?", <http://budget.house.gov/fy2015/settingtherecordstraight.htm>. The Part D doughnut hole is a gap in coverage during which enrollees, prior to ACA, had to pay for most or all of their drug costs. ACA phases out the doughnut hole through a combination of manufacturer discounts for brand name drugs and Medicare subsidies. When the doughnut hole is fully phased out in 2020, enrollees will be responsible for about 25% of their drug costs, the same as they pay during the coverage period before hitting the doughnut hole. In a November 4, 2010, letter to Chairman Ryan (at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/116xx/doc11674/11-04-drug_pricing.pdf), CBO indicated that the doughnut hole closure provisions would "make federal costs for Medicare's drug benefit and the costs faced by some beneficiaries slightly higher than they would be in the absence of those provisions, while the new discounts would make the costs faced by other beneficiaries substantially lower."

²⁵ As the ACA contains numerous Medicare provisions (primarily in Titles III and VI), the Section 301 and 302 ACA-related reserve funds would also allow for the repeal of and/or changes to Medicare specific provisions in the ACA.

²⁶ This would mainly include provisions that modify provider and Medicare Advantage payment methodologies. For additional details, see CRS General Distribution Memorandum, *Estimates of Medicare Savings in the Patient Protection and Affordable Care Act*, by Patricia A. Davis, August 31, 2012, available to congressional clients upon request.

without it being deficit-neutral.²⁷ This reserve fund would thus allow for higher federal spending, including Medicare spending, regardless of whether it would increase the budget deficit.

The budget resolution also accommodates legislation that fixes the Medicare physician payment (SGR) formula for the next 10 years. Specifically, Section 304 of H.Con.Res. 96 would provide procedural flexibility to allow for the consideration within the framework of the budget resolution of legislation that would reform the sustainable growth rate system, as long as the legislation did not increase the deficit for the period FY2015-FY2024.²⁸ The committee report does not suggest specific changes to the payment methodology, but proposes as an “illustrative policy option” that the new system provide incentives to improve the quality and efficiency of care provided to Medicare beneficiaries.²⁹ This policy option also proposes a requirement that CMS assume an override of scheduled reductions in physician payments when setting payment rates for Medicare Advantage plans, similar to the methodology the agency used in determining payments for 2014.³⁰

In addition, the budget resolution assumes a repeal of the Independent Payment Advisory Board (IPAB) created by the ACA.³¹ Under current law, beginning in 2014, the IPAB is required to develop proposals to reduce the Medicare per capita expenditure growth rate if Medicare spending is projected to exceed a certain target.³² To date, however, no board members have been nominated to serve on the IPAB and the board has not yet been established. Further, in its April 2014 baseline, CBO projected that the rates of growth in spending per beneficiary would be below the target rates of growth for fiscal years 2015 through 2024.³³ Recent CBO legislative cost estimates, however, have noted that the increased spending associated with permanently fixing the physician payment rates would “increase the likelihood that the IPAB mechanism would be triggered.”³⁴ Thus, the repeal of IPAB coupled with a repeal of the SGR physician payment system could mean that additional costs may need to be offset.

²⁷ H.Rept. 113-403, Medicare in Brief, p. 7, proposes a full ACA repeal.

²⁸ CBO has estimated that fixing this payment rate would cost about \$124 billion over this period. Congressional Budget Office, *Updated Budget Projections: 2014 to 2024*, supplemental data on “Budgetary Effects of Selected Policy Alternatives Not Included in CBO’s Baseline,” April 14, 2014, at <http://www.cbo.gov/publication/45229>.

²⁹ H.Rept. 113-403, p. 81.

³⁰ Prior to 2014, CMS calculated the national per capita Medicare Advantage (MA) growth percentage based on current law, including, when applicable, assumptions of physician payment reductions under SGR. For 2014, CMS determined MA rates based on the assumption that the scheduled 2014 25% reduction in physician payments would not occur. (Subsequent legislation in 2013 and 2014 did prevent those payment reductions.) See CMS, *Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 1, 2013, <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/RateNotice.pdf>.

³¹ H.Con.Res. 96, Policy Statement on Medicare, Section 604(a)(3)(D) and H.Rept. 113-403, p. 81. For additional information on IPAB, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

³² The proposals are not to “include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums ..., increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.” (ACA Section 3403, as modified by Section 10320.)

³³ Congressional Budget Office, *April 2014 Medicare Baseline*, April 14, 2014, at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf>.

³⁴ CBO cost estimates of S. 1871, SGR Repeal and Medicare Beneficiary Improvement Act of 2013, January 24, 2014, <http://www.cbo.gov/publication/45045>, and of H.R. 2810, SGR Repeal and Medicare Beneficiary Access Act of 2013, January 24, 2014, <http://www.cbo.gov/publication/45040>. Based on the legislation reviewed, CBO estimated that the savings from triggering the IPAB mechanism would be a \$0.5 billion to \$0.6 billion reduction in Medicare spending over the FY2015-FY2023 period.

Long-Term Medicare Changes (FY2024 and Beyond)

The budget assumes that the current Medicare defined benefits program will be changed into a fixed federal contribution (“premium support”) system beginning in 2024 for newly eligible beneficiaries. Assumptions regarding the broad parameters of the new system are outlined in Section 604, the “Policy Statement on Medicare,” of H.Con.Res. 96. The *Path to Prosperity* document and the committee report offer additional detail on suggested changes.

As previously noted, while a budget resolution may suggest policy changes, separate legislation would need to be developed by the committees of jurisdiction and enacted into law to effect such changes. As such, the committee report includes these proposals as “Illustrative Policy Options.”³⁵

Age of Medicare Eligibility

The committee report suggests that beginning in 2024, the age of eligibility for Medicare be gradually increased so that it would eventually correspond to the Social Security retirement age (age 67).³⁶

Conversion of Medicare to a Premium Support System

In the illustrative policy option described in the committee report,³⁷ current Medicare beneficiaries and individuals who become eligible for Medicare prior to 2024 (i.e., those who were 55 or older in 2013) would remain in the current Medicare program. Individuals who become eligible for Medicare beginning in 2024 would be given the choice of enrolling in a private insurance plan or a traditional fee-for-service option through a newly established Medicare exchange, and beneficiaries would be able to choose from a range of guaranteed-coverage options.³⁸ Those who qualify for Medicare prior to 2024 would also be given the option of switching to the new system.

Plans would be required to accept all people eligible for Medicare who apply, regardless of age or health status. Depending on which plan a beneficiary selects, Medicare would pay for all or part of the plan premium. The amount of premium support provided to high-income individuals would be reduced, while low-income beneficiaries would be provided assistance to help pay premiums, co-pays, and other out-of-pocket costs. In traditional Medicare, there would be a single deductible and supplemental policies would be “reformed.” The proposal suggests that program cost growth would be mitigated through market competition, with providers competing on the basis of price and quality.

³⁵ H.Rept. 113-403, p. 79.

³⁶ H.Rept. 113-403, p. 80.

³⁷ H.Rept. 113-403, p. 79. While the language of the “Policy Statement on Medicare” in H.Con.Res. 96 is almost identical to that in last year’s budget resolution (H.Con.Res. 25), the supplemental documents contain less specificity in the illustrative policy option about how the premium support system could be structured, and mainly provide broad parameters. For example, unlike the FY2014 proposal, the FY2015 budget proposal does not suggest limits on annual per capita Medicare spending growth, provide details on how plan bidding could occur, or suggest how federal financial support might be established in relation to the bids of participating health plans.

³⁸ The first year of the premium support system (2024) and those who would be required to enroll in the new system (those age 55 and over in 2013) in the FY2015 policy option did not change from the option included in the FY2014 House budget. As such, the FY2015 option suggests that the Medicare structural changes would begin in the last year of the budget window (2024) rather than outside of the budget window as in last year’s proposal.

Potential Impact

The impact of the proposed Medicare changes on the federal government, beneficiaries, and health care plans and providers would ultimately depend on how such a premium support system were designed and implemented. As noted, the premium support model was suggested in the conference report as an “illustrative policy option,”³⁹ and as such, provides a starting point for further analysis and discussion.

Numerous decisions, ranging from fundamental social policy decisions about the appropriate nature and level of federal financial support of the elderly to detailed administrative decisions, would need to be made as part of designing such a system. For example, decisions would need to be made regarding which parts of Medicare would be financed through premium subsidies. This could include determining whether Parts A and B (and possibly D) and their trust funds and funding sources would be combined; whether changes would be made to the voluntary nature of Parts B and D (or could one opt out of Medicare entirely); and whether beneficiary premiums would be based on expected per capita Part B and D costs, or whether they would also include the costs of Part A (which is now premium free for most enrollees).

Decisions would also need to be made regarding whether Medicare Advantage would still be an option in or after 2024 for those age 55 and older in 2013, or whether private plans would only be available through the exchanges, and whether the financial risk to private plans participating in the exchanges would need to be mitigated to encourage participation (e.g., Part D provides reinsurance for catastrophic costs and has risk corridors to limit losses).⁴⁰ Finally, an administrative infrastructure, including information technology systems, would need to be designed to administer both the old and new programs, including managing the bidding process for private plans, reimbursing plans and providers, educating and enrolling beneficiaries, and providing financial and quality of care oversight.

A CBO analysis⁴¹ of two illustrative premium support system models generally found that such models may reduce federal spending, but that beneficiaries’ premiums could be higher or lower depending on which model is implemented and in which plan they enroll. For example, in some regions, premiums for traditional fee-for-service Medicare could be higher than under current law. In its analysis, CBO assumed that there would be no limit on the growth rate for federal contributions, and that all Medicare beneficiaries, other than those dually eligible for both Medicare and Medicaid, would be enrolled in the new system (not just new beneficiaries). CBO noted that federal savings would be “substantially lower over an extended period if all current beneficiaries stayed in the existing Medicare system and only new enrollees participated in the premium support system.”

³⁹ H.Rept. 113-403, p. 79.

⁴⁰ If the model suggested in the budget proposal is used as the basis for designing a premium support system, the relationship between Medicare Advantage (current program) and private plans offered under the exchanges (premium support system) could be especially important in the early years of phasing in the new system. For example, in 2024, when individuals first start aging into the new Medicare program, private plans may be less willing to participate in both the current and new programs at a time when only a small number of beneficiaries would be enrolled in the new system.

⁴¹ CBO, “A Premium Support System for Medicare: Analysis of Illustrative Options,” September 2013, <http://www.cbo.gov/publication/44581>.

Medicaid

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports.⁴² Medicaid is jointly funded by the federal government and the states.⁴³ In FY2014, federal Medicaid payments to states are estimated to reach \$299 billion, and federal Medicaid spending is expected to reach about 1.7% of GDP.⁴⁴

Each state designs and administers its own version of Medicaid under broad federal rules. While states that choose to participate in Medicaid must comply with all federally mandated requirements, state variability is the rule rather than the exception in terms of eligibility levels, covered services, and how those services are reimbursed and delivered. ACA makes changes along these dimensions for the Medicaid program. Some of the changes are mandatory for states, and others may be implemented at state option.

The committee and *Path to Prosperity* reports propose to make two significant programmatic changes to the Medicaid program. The proposal would repeal certain Medicaid provisions in ACA and convert Medicaid into a block grant program. In addition to these programmatic changes, the budget proposal suggests significant reductions to federal Medicaid funding.

Repeal of Certain Medicaid Provisions in ACA

The Medicaid provisions of ACA represent the most significant reform to the Medicaid program since its establishment in 1965. The most notable change is the optional expansion of Medicaid eligibility for individuals under the age of 65 with incomes up to 133% of the federal poverty level.⁴⁵ Other ACA provisions include (1) the addition of both mandatory and optional benefits to Medicaid, (2) an increase in the federal matching payments for certain groups of beneficiaries and for particular services provided, (3) the provision of new requirements and incentives for states to improve quality of care and encourage more use of preventive services, and (4) additional Medicaid program changes.⁴⁶ The major expansion and reform provisions in ACA took effect January 1, 2014.

⁴² For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

⁴³ For more information about Medicaid financing, see CRS Report R42640, *Medicaid Financing and Expenditures*, by Alison Mitchell.

⁴⁴ Congressional Budget Office, *Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline*, April 14, 2014, at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf>.

⁴⁵ ACA establishes 133% of federal poverty level (FPL) based on modified adjusted gross income (MAGI) as the new mandatory minimum Medicaid income eligibility level. The law also specifies that an income disregard in the amount of 5% FPL must be deducted from an individual's income when determining Medicaid eligibility based on MAGI. Thus the effective upper income eligibility threshold for such individuals in this new eligibility group will be 138% FPL. Originally, the assumption was that all states would implement the ACA Medicaid expansion in 2014 as required in statute because implementing the ACA Medicaid expansion was required in order for states to receive any federal Medicaid funding. However, on June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business (NFIB) v. Sebelius* finding that the federal government cannot terminate the federal Medicaid funding a state receives for its current Medicaid program if a state does not implement the ACA Medicaid expansion, which effectively makes the ACA Medicaid expansion optional for states.

⁴⁶ For more information about the Medicaid provisions in ACA, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

The “illustrative policy options” offered in the committee report (H.Rept. 113-403) include repealing the ACA Medicaid expansion and other associated provisions in the ACA.

Conversion of Medicaid to a Block Grant System

Another “illustrative policy option” included in the committee report is the restructuring of Medicaid from an individual entitlement program⁴⁷ to a block grant program.⁴⁸ Few details are available regarding the specific design of the proposed block grant. The proposal indicates that (1) federal funding to states would increase annually according to inflation (CPI-U) and population growth, and (2) states would be provided additional flexibility to design and administer their Medicaid programs. In addition, the budget proposal would merge the State Children’s Health Insurance Program (CHIP)⁴⁹ into the Medicaid program.

Proponents of the block grant model suggest that this design would make federal Medicaid spending more predictable and provide states with stronger incentives to control the cost of their Medicaid programs. In addition, this design could relieve some of the cost burden to states by removing certain federal Medicaid requirements.⁵⁰

Block grant critics argue that block grants can undermine the achievement of national objectives and can be used as a “backdoor” means to reduce government spending on domestic issues. They also argue that the decentralized and variable nature of block grant programs makes it difficult to measure block grant performance and to hold state and local government officials accountable for their decisions.⁵¹

Reductions to Federal Medicaid Funding

The estimate provided in the committee report states that repealing the ACA Medicaid expansion would reduce federal Medicaid expenditures by \$792 billion over the budget window (i.e., FY2015 to FY2024).⁵² In addition to the savings from repealing the ACA Medicaid expansion, the committee report assumes \$732 billion in reductions to federal Medicaid expenditures over the 10-year period.⁵³ Together these reductions amount to \$1.5 trillion over the 10-year budget window, which is a 33% reduction in federal Medicaid funding when compared to CBO’s February 2014 baseline projection for federal Medicaid spending.⁵⁴

⁴⁷ Individual entitlement means that individuals who meet state eligibility requirements, which must also meet federal minimum requirements, are entitled to Medicaid.

⁴⁸ Historically, the term “block grant” has been used to mean programs for which the federal government provides state governments with a fixed amount of federal funds generally for administering and providing certain services to targeted groups of individuals.

⁴⁹ CHIP provides health coverage to nearly 8 million children in families with incomes too high to qualify for Medicaid. Like Medicaid, CHIP is administered by the states and is jointly funded by the federal government and states. However, the federal matching rate for state CHIP programs is 8 to 15 percentage points higher than the Medicaid matching rate for that state.

⁵⁰ For additional information on block grants, see CRS Report R40486, *Block Grants: Perspectives and Controversies*, by Robert Jay Dilger and Eugene Boyd.

⁵¹ Ibid.

⁵² H.Rept. 113-403, p. 76.

⁵³ Ibid., p. 75.

⁵⁴ Congressional Budget Office, *The Budget and Economic Outlook: FY2014 to FY2024*, February 2014.

According to CBO's analysis of similar proposals in previous years, even with the efficiency gains that could be realized by converting Medicaid to a block grant program, the magnitude of the federal Medicaid spending reductions under this proposal would make it difficult for states to maintain their current Medicaid programs.⁵⁵ As a result, states would have to weigh the impact of maintaining current Medicaid service levels against other state priorities for spending. They could choose to constrain Medicaid expenditures by reducing provider reimbursement rates, limiting benefit packages, and/or restricting eligibility. These changes could also affect the access to and the quality of medical care for Medicaid enrollees. For example, if states reduce the Medicaid reimbursement rates to providers, such as hospitals, physicians, and nursing homes, these providers may be less willing to participate in Medicaid at all or accept new Medicaid patients.

Private Health Insurance

Private health insurance covers over 199 million people in the United States.⁵⁶ Workers and their families often receive health insurance as a fringe benefit from their employers. However, some individuals and families purchase private insurance on their own.

Reflecting the attributes of these different "customers" for insurance (larger firms, smaller firms, and individuals), the private market offers insurance "products" through three distinct market segments: the large group market, the small group market, and the nongroup (individual) market. While these market segments are subject to different sets of regulatory standards, many of those standards are similar, especially between the non-group and small group markets. While states remain the primary regulators of the private insurance market, ACA's insurance market reforms and programs expand the federal role with respect to regulation of this industry and enforcement of standards.

ACA's private market provisions were designed to expand federal standards applicable to the private health insurance market, and increase access to coverage, such as establishment of exchanges (marketplaces) to offer private health insurance options to individuals and small employers. The law also subsidizes private insurance premiums and cost-sharing for certain lower-income individuals and families enrolled in exchange plans, among other provisions. These costs are projected to be offset by reduced spending for public coverage, and by increased taxes and other revenues. ACA's private market provisions also establish programs to mitigate risk across health plans: reinsurance, risk corridors, and risk adjustment.⁵⁷

Repeal of Private Health Insurance Provisions in ACA

As described earlier, H.Con.Res. 96 contains a reserve fund (Section 301) that would provide procedural flexibility to allow for the consideration of legislation that would fully repeal ACA, as amended, without it being deficit-neutral. H.Con.Res. 96 also contains another reserve fund (Section 302) that would provide procedural flexibility to allow for the consideration of legislation to reform or replace ACA, as long as the measure were deficit-neutral.

⁵⁵ Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, March 2012.

⁵⁶ U.S. Census Bureau, *Current Population Survey, Table HI01, Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2012*, http://www.census.gov/hhes/www/cpstables/032013/health/h01_000.htm.

⁵⁷ For a summary of ACA's private insurance provisions, see CRS Report R43048, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach.

The committee report indicates that the budget provides for a repeal of the ACA, including the exchange subsidies,⁵⁸ and suggests that approximately \$1.2 trillion could be saved over 10 years (beginning FY2015) due to repeal of the federal outlays associated with exchange subsidies and other exchange-related spending.⁵⁹ The committee report also notes that the budget assumes a full repeal of the ACA tax increases as part of a broad deficit-neutral reform of the tax code.⁶⁰ Finally, a policy statement in H.Con.Res. 96 suggests that the establishment of high risk pools be included as part of a replacement to the ACA.⁶¹

Other Health Care Proposals

Medical Malpractice

Medical malpractice has attracted congressional attention numerous times over the past few decades, particularly in the midst of three “crisis” periods for medical malpractice liability insurance in the mid-1970s, the mid-1980s, and the early 2000s. These periods were marked by sharp increases in medical liability insurance premiums, difficulties in finding any liability insurance in some regions and among some specialties as insurers withdrew from providing coverage, reports of providers leaving areas or retiring following insurance difficulties, and a variety of public policy measures at both the state and federal levels to address the market disruptions. In each case, attention receded to some degree after a few years as premium increases moderated and market conditions calmed.

The overall medical liability insurance market is not currently exhibiting the same level of crisis as in previous time periods. Nonetheless, problems with the affordability and availability of malpractice insurance persist, especially in particular regions and physician specialties (e.g., obstetricians). In addition, concern about claims for medical malpractice may affect individual provider decisions, particularly through increased use of tests and procedures to protect against future lawsuits (“defensive medicine”), which may affect health care costs. The malpractice system also experiences issues with equity and access. For example, some observers have criticized the current system’s performance with respect to compensating patients who have been harmed by malpractice, deterring substandard medical care, and promoting patient safety.⁶²

As an “illustrative policy option,” the committee report indicates that the budget supports certain changes to medical liability laws.⁶³

⁵⁸ H.Rept. 113-403, p. 76. Section 305 of H.Con.Res. 96 creates a reserve fund that allows for a deficit-neutral reform of the tax code; the related policy statement may be found in Section 602.

⁵⁹ The savings estimate is based on CBO figures in its “The Budget and Economic Outlook: 2014 to 2024, Appendix B: Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act,” February 4, 2014, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf>. The spending estimate also includes the grants to states for the operation of exchanges, and collections and payments for reinsurance, risk corridors, and risk adjustment.

⁶⁰ H.Rept. 113-403, p. 77.

⁶¹ H.Con.Res. 96, Section 603(b).

⁶² CRS Report R41693, *Medical Malpractice: Overview and Legislation in the 112th Congress*, by Baird Webel, Vivian S. Chu, and Amanda K. Sarata.

⁶³ Suggestions for specific reforms were not provided. H.Rept. 113-403, p. 81.

Author Information

Patricia A. Davis
Specialist in Health Care Financing

Bernadette Fernandez
Specialist in Health Care Financing

Alison Mitchell
Analyst in Health Care Financing

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